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| **Case Number:** | CM13-0064102 | | |
| **Date Assigned:** | 01/03/2014 | **Date of Injury:** | 12/02/2010 |
| **Decision Date:** | 04/04/2014 | **UR Denial Date:** | 11/21/2013 |
| **Priority:** | Standard | **Application Received:** | 12/11/2013 |

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery has a subspecialty in Sports Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 48-year-old female who reported an injury on 12/02/2010. As of 09/10/2013, the documentation indicates the patient had undergone 10 failed physical therapy sessions which reportedly gave her temporary relief and had received 1 right shoulder cortisone injection and right elbow cortisone injection. The patient was most recently seen on 11/12/2013 with complaints of neck pain rated at 7/10, right shoulder pain rated as a 7/10 to 8/10, left shoulder pain rated as a 9/10, bilateral elbow pain rated at a 7/10, right wrist pain as a 7/10 and low back pain rated as a 7/10. As of that date, the patient had undergone 3 cortisone injections to the right shoulder and 1 to the left shoulder which had helped for approximately 3 months, and had reportedly undergone a previous right shoulder surgery. Physical examination of the elbow noted tenderness over the right lateral epicondyle, with flexion and extension normal, with the patient having a positive Mills lateral epicondylitis noted on the right, negative on the left, with a Tinel's and elbow flexion test positive on the left and negative on the right. A reverse Mills, Cozen's, valgus and varus test are all negative bilaterally and the patient only had mild decreased in range of motion of the left wrist at 55 degrees forward flexion and extension. On the orthopedic exam, the patient had a positive Tinel's and Phalen's on the left and negative on the right, with a Watsons Scaphoid shift, lunotriquetral shear test, mid carpal instability, reverse Phalen's, median n. comp and Finklestein's test all negative bilaterally.

## IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**The request for Right Elbow Lateral Epicondyle Release and Repair Surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 44-45.

**Decision rationale:** According to Shoulder Complaints ACOEM Guidelines, there is a current debate regarding whether lateral epicondylalgia is an inflammatory condition or an enthesopathy and what treatments would be most appropriate. It further states that conservative treatment should be maintained for a minimum of 3 to 6 months, with some individuals improving with surgery; however, there is no publish or CTs that indicate that surgery improves the condition over nonsurgical options. It goes on to state that this condition has a tendency to spontaneously improve over time. In the case of this patient, the most recent documentation does not indicate the patient is having any significant issues with her right elbow. Although, she tested positive for epicondylitis, the patient was noted to have full range of motion, with negative results on the remainder of the tests. With the guidelines referencing of this condition can spontaneously improve over time, and the patient having undergone minimal conservative treatments, surgical intervention is considered excessive in this case and is not considered medically appropriate. As such, the requested service is non-certified.

**The request for Left Wrist Carpal Tunnel Release Surgery:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** According to Forearm, Wrist, and Hand Complaints Chapter ACOEM Guidelines, carpal tunnel syndrome does not produce hand or wrist pain, and is most often the cause of digital numbing or tingling primarily in the thumb, index and long finger or along the wrist. Furthermore, patients would have symptoms of decreased grip strength, including difficulty picking up small objects, and hand pain radiating into the forearm. The patient may also have numbness and tingling in the thumb, index, middle fingers, and especially at night or with activity. In the case of this patient, the documentation does not provide information indicating the patient has numbness or tingling along the wrist or hand to include the phalanges. There is also no documentation of decreased grip strength or difficulty in picking up small objects. Aside from having a positive Tinel's and Phalen, the only other objective findings are a mild decrease in flexion and extension, and the complaint of left wrist pain. At this time the patient does not meet guideline criteria for a carpal tunnel release or repair surgery. As such, the request service is non-certified.

**The request for Left Shoulder Arcomioplasty:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**Decision rationale:** According to Shoulder Complaints at ACOEM Guidelines, this procedure is not indicated for patients with mild symptoms or those who have not undergone conservative treatments including cortisone injections for at least 3 to 6 months prior to surgery. Official Disability Guidelines has also been referred to in this case and states that subjective findings for criteria for an acromioplasty must show that the patient has pain with active arc motion of 90 to 130 degrees and pain at night. Furthermore, imaging studies to include conventional x-rays, AP, and true lateral or axillary views and a Gadolinium MRI, ultrasound, or arthrogram must show positive evidence of impingement. In the case of this patient, the most recent diagnostic study was an MRI performed in 09/2013 which diagnosed the patient as having acromioclavicular osteoarthritis, supraspinatus tendonitis and infraspinatus tendonitis. There was no conclusive evidence that the patient has impingement syndrome and no clinical documentation of pain with active arc motion of 90 to 30 degrees. Because the patient does not meet the guidelines criteria for an acromioplasty, the requested service and its entirety cannot be supported. As such, the requested service is non-certified.

**The request for Post Operative Physical Therapy 2 times a week for 6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**The requested treatment for Prilosec:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (NSAIDs) non-steroidal anti-inflammatory drugs , GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to Chronic Pain Medical Treatment Guidelines, patients at intermediate risk for gastrointestinal events no cardiovascular disease may benefit from the use of a proton pump inhibitor. In the case of this patient, the current documentation does not provide a medication list nor did the physician indicate the patient is suffering from any form of gastrointestinal events at this time. The physician has also failed to provide dosage and number of tablets to be dispensed. Furthermore, this medication is not to be used prophylactically, and as the patient has not been diagnosed with any GI issues, the requested service is not considered medically necessary and is non-certified.